						PKIN	TED:	10/03/2011
EPARTMENT	T OF HEALTH AND HUN	IAN SERVICES				FOI	RM APPI	ROVED
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 09	938-0391
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CC	NSTRUCTION	(X3) DATE	SURVEY	•
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, ріші	DING	00	COMPL	ETED	
		15G442				08/26/2011		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN47130				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		((X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMP	LETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN47130 CIES ID PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED OR/26/2011 COMPLETED OR/26/2011	ATE				
WOOO			1					

	This visit was for a fundamental recertification and state licensure survey.	W0000		
	Survey Dates: August 17, 18, 19, 22 and 26, 2011			
	Facility Number: 000956 Provider Number: 15G442 Aim Number: 100244760			
	Surveyor: Jo Anna Scott, Medical Surveyor III			
	These deficiencies also reflect state findings in accordance with 431 IAC 1.1. Quality Review completed 9/12/11 by Ruth Shackelford, Medical Surveyor III.			
W0104	The governing body must exercise general policy, budget, and operating direction over the facility.			
	Based on record review and interview for 1 of 8 clients living in the home (client #8), the governing body failed to exercise operating direction over the facility to ensure the client's personal funds were not	W0104	Corrective Action: (Specific) The Program Coordinator and Accounts Payable will be retrained that a client's personal fund will not be used for professional services, such as a root canal. Client #8 will be	09/27/2011
LABORATO	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN.	ATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00	COMPL	ETED
		15G442	B. WIN			08/26/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	ļ.	
NAME OF I	PROVIDER OR SUPPLIE	R		1	/ING LN		
RES CARE COMMUNITY ALTERNATIVES SE IN				1	RSONVILLE, IN47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	used to provide	a root canal.			reimbursed the \$250.00 for her canal.	root	
	Findings include) :			How others will be identified: (Systemic) The Program Coord	linator	
	The record revie	ew of finances was			at each home will ensure that n	o	
	conducted on 8/	18/11 at 8:30 AM. The			personal funds will be used to j	-	
	Resident Fund N	Management Service			for professional services, such	as a	
		t for client #8 indicated a			root canal.		
		on was made on 7/28/11.			Massures to be put in place.	ГЬо	
	·	for the deduction			Measures to be put in place: 'Program Coordinator and Acco		
		duction was for a root			Payable will be retrained that a		
		duction was for a root			client's personal fund will not b		
	canal.				used for professional services,		
		22 //4			as a root canal. Client #8 will l	be	
	Interview with s				reimbursed the \$250.00 for her	root	
	Manager/QMRF	P, on 8/18/11 at 8:45 AM			canal.		
	indicated Medic	are wouldn't pay for the					
	root canal and si	nce she had some money			Monitoring of Corrective Acti		
	they used her pe				Client finance records are revie		
	1 -	taff #10, Accounts			monthly by the Accounts Payal Department. The Director of	ole	
		2/11 at 2:30 PM indicated			Finance will monitor and ensur	e that	
	1 2 7				no client personal funds are bei		
	I -	used from the clients			used for professional services,		
	1 -	t and they would enter a			as a root canal.	Jucii	
	1 *	on request. Staff #10					
	indicated if and	when they got the					
	reduction, they	would reimburse the					
), indicated she did not					
		it would take for the					
	_	to be made to the client.					
	Tellifoursement (o of made to the chefft.					
	1.1-3-1(a)						
	1.1-3-1(a)						

STATEMENT OF DEFICIENCIES X1) PROVIDE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE S	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPL	ETED
		15G442	B. WIN			08/26/2	011
			F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				VING LN		
RES CARE COMMUNITY ALTERNATIVES SE IN		_		RSONVILLE, IN47130			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0125	clients. Therefore	nsure the rights of all , the facility must allow and ual clients to exercise their					
		the facility, and as citizens					
		es, including the right to file					
	complaints, and th	e right to due process.					
	Based on record	review and interview for	W	0125	Corrective Action: (Specific)	Γhe	09/27/2011
	2 of 8 clients livi	ng in the home (clients			Program Coordinator will be		
	#2 and #7), the fa	acility failed to ensure the			retrained that all Health Care Representatives must be a famil	x,	
	Health Care Repr	resentative (HCR) was a			member, clergy, or court appoir		
	family member,	clergy, or court ordered.			members if the IDT agrees the o		
	,	237			needs a Health Care Representa	- I	
	Findings include				The Program Coordinator held a		
	i mamgs merade	•			IDT for Client #7 and determine	ed	
	The 8/17/11 Peri	idential Facility Surveyor			that the client needs a Health Ca		
		eviewed 8/17/11 at 10:30			Representative. The IDT for cli		
					#7 will also attempt to identify a Health Care Representative who		
		heet listed all the clients			family member, clergy, or an) 15 a	
	_	e and indicated if they			individual who agrees to follow	the	
	•	by a guardian, HCR or			legal process to be appointed by		
		s #2 and #7 were listed			court. The IDT for Client #2 m		
	with the same HO	CR.			and completed a Comprehensiv		
					Functional Assessment. The tea		
	Interview with st	aff #1, Home			determined that Client #2 is able		
	Manager/Qualific	ed Mental Retardation			make informed decisions on her healthcare needs. The IDT will		
	Professional on 8	8/22/11 at 1:30 PM			continue to review Client #2's		
	indicated clients	#2 and #7 did not have			competencies and if the status		
		ould act as their health			changes, the team will indentify	a a	
	care representative. Staff #1 indicated				Health Care Representative for	the	
	-	nd church and didn't			individual.		
	-	. Staff #1 indicated the			How others will be identified:	ol ICD	
		as someone that wanted			(Systemic) At each client annu meeting, comprehensive function		
	•	indicated she was not			assessments will be reviewed so		
	*				IDT can make a decision if a He		
		nad to be a family			Care Representative is needed f		
	member, clergy of	or court appointed.			individual. The team will seek		
					Health Care Representative who	o is	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S		
		A. BUIL	DING	00	COMPL		
		15G442	B. WING			08/26/2	011
			1	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		402 EWING LN				
RES CAF	RE COMMUNITY AL	TERNATIVES SE IN			RSONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re I	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1.1-3-2(a)				either a relative of the client or	a	
					member of the clergy.		
					Measures to be put in place:	The	
					Program Coordinator will be		
					retrained that all Health Care		
			1		Representatives must be a famil	-	
			1		member, clergy, or court appoir		
			1		members if the IDT agrees the o		
			1		needs a Health Care Representa		
			1		The Program Coordinator held a IDT for Client #7 and determine		
					that the client needs a Health Ca		
					Representative. The IDT for cli #7 will also attempt to identify		
					Health Care Representative who		
					family member, clergy, or an) is a	
					individual who agrees to follow	the	
					legal process to be appointed by		
					court. The IDT for Client #2 m		
					and completed a Comprehensiv		
					Functional Assessment. The tea		
					determined that Client #2 is able	e to	
					make informed decisions on her	r	
					healthcare needs. The IDT will		
					continue to review Client #2's		
					competencies and if the status		
					changes, the team will indentify		
					Health Care Representative for	the	
					individual.		
			1		Monitoring of Corrective Action		
					The Program Coordinator will a	issure	
					that at all annual client ISP	1	
					meetings, comprehensive functi		
					assessments are reviewed to see		
					Health Care Representative is n		
					for the individual. Contacts will made for the Health Care	ve	
					Representative to be a relative of member of the clergy.	ла	
					member of the clergy.		
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DLFI11

Facility ID:

000956 If

If continuation sheet Page 4 of 8

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G442 08/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 402 EWING LN RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must have evidence that all W0154 alleged violations are thoroughly investigated. Corrective Action: (Specific) The W0154 Based on record review and interview for 09/27/2011 Director of Quality Assurance will 1 of 4 sampled clients (client #2), the retrain the Quality Assurance Staff facility failed to conduct an investigation that all elopements must be of elopement from the home. thoroughly investigated Findings include: How others will be identified: (Systemic) The Program The BDDS (Bureau of Developmental Coordinators for each home will Disability Services) incident reports were report all alleged violations, reviewed on 8/17/11 at 12:34 PM. The including elopement, to Quality incident report for client #2 dated 8/1/11 Assurance. The Quality Assurance Team will investigate all indicated the following: elopements. "[Client #2] came to the med room to take her 8 PM med's. Told me she was done Measures to be put in place: The listen (sic) to the loud voices in the house Director of Quality Assurance will retrain the Quality Assurance Staff and that she was going to her room. The that all elopements must be next thing I know she walked out the front thoroughly investigated door. I had the other staff walk outside with her when [client #2] stated she was **Monitoring of Corrective Action:** going walking. Staff went to look for The Director of Quality Assurance will report all violations, including [client #2] and while I was gone (another elopement, immediately to the group home) called and said [client #2] Executive Director for the Executive was over there." The other group home is Director to review for appropriate 2.3 miles from client #2's home. There action to be taken. The Executive was no investigation of the elopement Director will assure investigations are completed as required. conducted. The record review for client #2 was conducted on 8/18/11 at 3:39 PM. The Individual Support Plan (ISP) dated 3/19/11 indicated client #2 had a formal training goals of "Will display

000956

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G442		ĺ	IULTIPLE COI ILDING	NSTRUCTION 00	COMPL	ETED	
		15G442	B. WIN			08/26/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
RES CAF	RES CARE COMMUNITY ALTERNATIVES SE IN				RSONVILLE, IN47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
ing		y skills with verbal	+	ing	·		DATE
		% of opportunities" and					
		rian safety skills when					
		nunity daily with 2 verbal					
	_	opportunities. The					
	1 ^	ement Plan dated 3/19/11					
	· ·	2 had Elopement					
		t #2] leaves the group					
	l	or workshop property)					
		ervision." included as					
	one of her targete	ed behaviors.					
	Interview with st	aff #1, Home					
	Manager/Qualifi	ed Mental Retardation					
	Professional, on	8/22/11 at 1:30 PM					
	indicated client #	⁴ 2 had eloped in the past.					
	Staff #1 indicated	d she did have					
	community acces	ss to walk to the park that					
	was across the st	reet. Staff #1 indicated					
		told the staff she was					
	_	her group home that was					
	a number of bloc	ks away.					
		00.115 0 111					
		aff #5, Quality Assurance					
	/	at 1:30 PM indicated					
	I -	n investigation because					
		nmunity access to walk to					
	the park.						
	1.1-3-2(a)						
	1.1 5 2(a)						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G442	B. WIN			08/26/2	011
			D. 1121		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				VING LN		
RES CARE COMMUNITY ALTERNATIVES SE IN			JEFFE	RSONVILLE, IN47130			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORREC			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
W0314		ntrol of inappropriate					
		monitored closely in ne physician and the drug					
		quirement at §483.460(j).					
		review and interview for	l w	0314	Corrective Action: (Specific	c)	09/27/2011
		lients (client #4), the			The PC will be in-serviced or	1	
	-	conduct quarterly			ensuring that all consumers		
	-	s of medication used to			receiving psychotropic		
	conduct inapprop				medications are seen by the psychiatrist at least every thr		
	conduct mapping	oriate beliaviors.			months. All consumers rece		
	D: 1: : 1 1				psychotropic medications wil	٠ ١	
	Findings include	:			seen by the psychiatrist at le	ast	
					every three months. How		
		w for client #4 was			others will be identified:		
	conducted on 8/1	8/11 at 11:42 AM. The			(Systemic) The Program Dir	ector	
	Behavior Suppor	t Plan (BSP) dated			will complete random observations of the medical		
	3/11/11 indicated	l client #4 received the			record to ensure that all		
	following medica	ations for behavior:			consumers receiving psycho	tropic	
	Clonazepam for	psychosis, Loxapine for			medications are seen by a	-	
	schizophrenia, G				psychiatrist at least every thr		
	schizophrenia an	•			months. Measures to be put		
	-	The records indicated			place: The PC will be in-ser on ensuring that all consume		
	client #4 had a fo				receiving psychotropic	13	
		/1/10, 1/3/11 and 5/2/11			medications are seen by the		
		dications. There was no			psychiatrist at least every thr		
					months. All consumers rece	- 1	
		edication had been			psychotropic medications wil		
	reviewed at any of	other times.			seen by the psychiatrist at le every three months. Monito		
		00.114			of Corrective Action: The	" "'y	
	Interview with st				Program Director will comple	te I	
	Manager/Qualified Mental Retardation				random observations of the		
	,	8/22/11 at 1:30 PM			medical record to ensure tha		
	indicated the doc	tor made the			consumers receiving psycho	tropic	
	appointments and	d she didn't know why he			medications are seen by a psychiatrist at least every thr	_	
	did client #4's ap	pointments at four month			months.		
	intervals.				montrio.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM 08/26	E SURVEY PLETED /2011
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			402 EW JEFFER	ADDRESS, CITY, STATE, ZIP O VING LN RSONVILLE, IN47130	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	1.1-3-5(a)					